DATE: April 21, 1998 DSL-BQA-98-003

TO: Nursing Homes NH 2

FROM: Judy Fryback, Director
Bureau of Quality Assurance

Counting, Using, and Reducing Physical Restraints

According to figures from the Health Care Financing Administration's data system, Wisconsin ranks second highest among the 50 states in the percentage of nursing home residents who are physically restrained. Year-end 1997 data shows that 26% of residents in Wisconsin's skilled nursing facilities are physically restrained compared to a national average of 16%.

Federal tag F221 [42 CFR 483.13(a)] requires that residents be free from physical restraints imposed for the purposes of convenience or discipline and not required to treat a medical symptom. During 1996, the Bureau of Quality Assurance (BQA) cited deficiencies of F221 at 9% of Wisconsin's nursing homes. This was the same as the national average. During 1997, the BQA cited a deficiency at F221 at 19% of the nursing homes that we surveyed. In both 1996 and 1997 we cited other facilities at F272 [42 CFR 483.20(b)] for not comprehensively assessing either the need for a restraint or the type of restraint.

The purpose of this memo is:

- To provide information about what a restraint is and how to count residents who are in restraints. (This is to correct possible inaccuracies in identifying what is or is not a physical restraint, which may partly account for Wisconsin's high use of physical restraints.)
- To inform you of our expectations for compliance with F221 and the restraint requirements in Chapter 50, Wisconsin Statutes, and Chapter HFS 132, Wisconsin Administrative Code for Nursing Homes.
- To provide information about the types of deficient practices we have identified in our citations at F221 (restraints), F272 (comprehensive resident assessment), and F324 ([42 CFR 483.25(h)(2)], adequate supervision and assistance devices to prevent accidents).
- To clarify any misunderstandings that may have developed about restraint use or the reduction of restraints. *This includes the misperception that facilities must be restraint-free and that residents who appear as examples on our restraint citations must be completely out of restraints by the revisit.*
- To clarify our expectations when families or guardians insist on using a restraint.

What is a restraint? What should you count as a restraint? The federal government defines a physical restraint as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." Similarly, sec. 50.09(1)(k), Wis. Stats., defines a physical restraint as including, but not limited to, "any article, device, or garment which interferes with the free movement of the resident and which the resident is unable to remove easily, and confinement in a locked room." The important characteristics of a restraint are that (1) it keeps a resident from freely moving or from reaching a part of his/her body, and (2) the resident cannot easily remove it.

The definitions mean that anything -- a reclining chair, a side rail, a table top, a sheet that is tied around a resident, a soft chair cushion that prevents a resident from rising, a physical hold, or a geri-chair -- may or may not be a restraint. *It is not helpful to say that one particular device is a restraint and that another device is not a restraint. Instead, it is better to think in terms that <u>any device may potentially be a restraint, depending upon how it is used, on whom it is used, and the effect upon whom it is used</u>.* A side rail may be a restraint for one person, but not another. Even a lap belt may be a restraint for one person but not for another.

The litmus test for determining if a garment, article, method, or device is a restraint consists of 2 questions: If the answer is "yes" to **both** questions, then the device is a restraint. If the answer to one or both questions is "no," the device is not a restraint. These questions relate to the **resident and the resident's capabilities, not the device**.

1. Does the device keep a resident from moving about or from reaching part of his/her body? Before answering this question, you must first determine what active movement the resident is voluntarily or involuntarily capable of making, given his/her functional abilities. Then consider the effect of the device. If the device (not the resident's capabilities) prevents a resident from freely making this movement (e.g., purposely or non-purposely moving about or from reaching a part of his/her body), then the device restricts movement. It may be a restraint. In other words, if the device prevents a resident from performing an action that s/he would otherwise be capable of performing, it may be a restraint.

> Example of a device that may be a restraint: A wedge cushion or a soft belt keeps a resident from getting out of a chair. This resident would otherwise be capable of getting out of the chair by getting up or by actively working to slide out of the chair. The device may be a restraint, depending on how easily the resident can remove the device (question 2). This is true even if the resident could not walk once out of the chair.
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> Examples of devices that are not restraints: (1) A wedge cushion is used as a positioning device to prevent a resident from passively sliding down in a chair. Even without the wedge cushion, the resident is not capable of getting out of the chair or working his/her way down the chair. The device is not a restraint. (In this example, a soft belt may also prevent sliding, but it may not be the most desirable, or safest, device. A soft belt often does not prevent a resident from sliding under it, thus creating a potentially hazardous situation.) (2) A resident repositions him or herself with the side rail, but the side rail does not prevent the resident from safely and easily getting out of the side of the bed. The side rail is not a restraint.

If the device is restricting free movement within the context of the resident's capabilities, the second question you must ask is:

2. Is it difficult for the resident to remove the device? If a resident cannot easily remove a device that is restricting movement the resident would otherwise be capable of making, the device is a restraint. Conversely, if the resident can easily remove the device, the device is not restricting the resident's movement. We would not consider the device to be a restraint.

National statistics that depict high restraint use in Wisconsin may be the result of errors in counting and recording restraints. We believe this because other statistics show that Wisconsin nursing home residents do not have higher rates than residents in other states of conditions commonly associated with the negative physical side effects from restraint use: pressure ulcers, incontinence, urinary tract infections, contracture, or immobility. Wisconsin may be over-counting or other states may be under-reporting. It is important, when calculating the number of residents in restraints, that you do not simply count the

number of residents using a device. Instead, you must look at how the device affects a resident's movement and whether or not the resident can easily remove the device. When reporting the number of residents in restraints on the HCFA-672 form, *Resident Census and Conditions of Residents*, you should count the number of residents who have a device that restricts movement the resident would otherwise be capable of making and which the resident cannot easily remove. You should not simply report the number of residents who have a device. For further information about whether a side rail is or is not a restraint, please see pages 7 and 8 of this memo.

BQA Expectations. It is our expectation that restraint use will be the exception rather than the rule. Any physical restraint must clearly benefit the resident, be **required** to treat the resident's medical symptoms, and lead to the highest practicable level of functioning for that resident. In no case may a facility use a physical restraint for purposes of discipline (to punish or penalize a resident) or for convenience (to control or maintain resident behavior with less effort by facility staff).

BQA expects facilities to use a comprehensive and systematic approach to assess residents' needs. A facility should always use an alternative to a restraint if the alternative will help the resident achieve his/her highest practicable level of functioning. If a restraint is the best method for meeting a resident's needs, facilities should use a logical process to determine the least restrictive restraint and the appropriate conditions for use to minimize application of the restraint. In addition, staff must re-evaluate the resident to determine if they can meet the resident's needs by using a less restrictive restraint or by approaches that do not include a restraint.

One sequence of assessment for determining whether or not a physical restraint is required might include steps 1- 11 listed below.

(1) Staff identify the safety issues/medical symptom for which a restraint is being considered. Medical symptoms are the manifestations of an underlying illness. They include both the subjective complaints of the resident as well as the objective data elicited by an examiner. Medical symptoms alone do not justify the use of a restraint, nor is there any one medical symptom that should automatically trigger their use. The Health Care Financing Administration has not, nor does it intend to, issue a list of conditions or symptoms that qualify as "acceptable" medical symptoms for using a restraint. This having been said, it is possible that too much attention has been focused on the term "medical symptom" and whether a particular condition exemplifies an acceptable medical symptom for using a restraint. Staff must focus on whether a restraint "... is **required to** treat a medical symptom." This places the emphasis for compliance upon the comprehensive assessment of the individual, the assessment of the underlying factors that contribute to the symptom, and the subsequent decision-making that led to choosing a physical restraint over other alternatives.

Depending upon the assessment, the treatment of one resident's medical symptom may lead to a completely different course of action than the treatment of another resident who has the same medical symptom. HCFA's expectation, like ours, is that staff will comprehensively evaluate each resident on an individual basis to determine what plan of care will enable the resident to attain or maintain his or her highest level of functioning and well being. It is the evaluation and assessment process that determines whether a given symptom is best treated by a physical restraint or some other means.

Contrary to some comments we have heard, it is NOT true that there are only three or four medical symptoms that qualify for restraint use. It is the assessment of the resident that ultimately determines whether a restraint is required to treat a symptom.

(2) Staff collect and evaluate data about the circumstances surrounding the symptom for which a restraint is being considered. When collecting data, staff might focus on:

- preceding events and conditions that may have triggered the symptom;
- if the concern is a behavior, such as wandering or getting up at night, what the purpose of the resident's behavior may be (for example, wanting to get up to go to the bathroom, or thinking s/he needs to go to work)
- patterns (e.g., locations and times of the day or night that the symptom occurs); and
- the effectiveness of any safety measures being used at the time.

(3) Staff comprehensively assess the resident, with the goal of identifying the underlying cause of the symptom. As part of the assessment process, staff should determine whether the underlying cause of the resident's symptom(s) is related to social, environmental, physiological, pharmacological, medical, or other conditions. Staff may assess the possible influence that each of the following have on the safety issue: resident posture, gait, vision, sense of balance, blood pressure changes, cognitive status, safety awareness, physical strength, muscle tone, rehabilitative status, memory, medications, social history, involuntary movements, activity needs, social skills, and staff response. (Note: The eight leading risk factors associated with falls are: postural hypotension; use of sedative, hypnotic and anti-hypertensive medications; use of four or more medications; unsafe transfer to toilet or bathtub; environmental hazards; gait impairment; decreased muscle strength and/or range of motion; and balance disturbance.)

We expect that staff documentation will lead us through the assessment process. If the documentation is not complete, we will ask staff to reconstruct and verbally explain the assessment process.

(4) Staff identify options and consider the risks and benefits of all identified treatment options for the individual resident. In light of the comprehensive assessment, staff will identify the interventions (e.g., social or environmental modifications, pharmacological changes, medical interventions, etc.) that they might use and will consider the risks and benefits of each. The purpose of assessing the pros and cons of each option is to identify the least restrictive approach, in light of specific individual risks such as previous history of falls, osteoporosis, poor protective response, coagulation time, etc., that best treats the condition underlying the resident's symptom. If a restraint is used, the positive benefits must outweigh the possible negative effects of strangulation, pressure sores, incontinence, contracture, loss of bone mass, increased weakness, loss of autonomy, dignity, self-respect, and independence and functional capacity associated with restraint use. Both the interdisciplinary team and the resident/legal representative should be comfortable with the final decision in light of all the risks and benefits.

One key to identifying the best intervention is knowledge of the resident's past and present levels of functioning and what level of functioning the resident might attain. It also is important that staff know what level of functioning is important to the resident and how intervention may improve the resident's quality of life. If staff determine, through a comprehensive assessment, that a resident is capable of walking and this is very important to the resident, the interdisciplinary team may recommend a strengthening program commensurate with a gradual reduction in the use of restraints. On the other hand, if the comprehensive assessment shows that the resident is not capable of walking again and that neurological deficits prevent the resident from understanding this, the resident's highest level of functioning may be sitting safely in a chair.

We expect that staff documentation will lead us through the options that were considered and the rationale for rejecting non-restraint alternatives. If this has not been documented, we expect that staff will be able to verbally walk the survey team through its complete considerations of risks and benefits.

(5) When indicated by the individualized comprehensive assessment, staff attempt less restrictive alternative measures prior to using a restraint. These may include environmental modifications (e.g., lowering a bed or getting a different type of bed, rearranging furniture, reducing glare) diversionary activities (e.g., walking a resident), or the implementation of care interventions such as hourly toileting or chair/bed alarms.

(6) Except when used in an emergency, staff fully inform the resident or legal representative of the findings and recommendations of the interdisciplinary team, and of the risks and benefits of restraints as opposed to other treatment alternatives. The resident or the legal representative will give informed consent to the use of a restraint prior to its use. We expect to find documentation that this occurred or that the decision-maker will verify this if we contact him or her.

Residents, family members and/or a legal representative have the right to actively participate in the assessment and care-planning process and to make informed choices based on their understanding of the pros and cons involved in different treatment options. Family members and legal representatives, however, do not have the right to dictate the use of a physical restraint when a restraint is not required to treat the resident's medical symptoms. (See page 9.)

(7) The physician orders the restraint. The physician order must include the resident's name, the reason for the restraint and the period during which staff will apply the restraint [sec. HFS 132.60(6)(b), Wis. Admin. Code]. In addition, the physician orders any medically necessary therapies or interventions needed to offset the debilitating effects of a restraint.

Neither state nor federal regulations explicitly require the physician to specify the type of restraint in his/her order. However, just as a physician would order "Vasotec 5 mg. daily" and would not order "a pill for high blood pressure," the standard of practice indicates that the physician should specify the type of restraint in his/her order.

(8) Staff correctly apply the physical restraint and use it only during the time period ordered. In some cases, staff will use the restraint only in conjunction with restorative nursing, range of motion, etc.

(9) Staff check a restrained resident as often as necessary but at least every two hours to reposition the resident and to see that the resident's needs are met [sec. HFS 132.60(6)(f), Wis. Admin. Code]. When restraints are used, it is critical that the restraint is frequently checked to prevent accidents and deaths from occurring.

(10) Staff document the use of a restraint on each tour of duty on which a restraint is used [sec. HFS 132.60(6)(g), Wis. Admin. Code].

(11) Staff periodically, but at least quarterly during the MDS review, re-evaluate the need for the restraint and the type of restraint being used. More frequent review may be necessary if the resident's condition changes. When the need for the restraint is eliminated, or when the restraint no longer provides a benefit to the resident, the restraint must be removed.

A facility may apply a physical restraint in a non-emergency only after a comprehensive, individual assessment leads to a determination that a restraint is **required** to treat a medical symptom and to allow the resident to reach his/her highest practicable level of functioning and well being. Once begun, there should be periodic evaluation of the need for the restraint and the type of restraint.

In an emergency, a nursing home may use a physical restraint without a physician's order (sec. HFS 132.31(1)(k), Wis. Admin. Code). We consider an emergency to be an unpredictable event in which the resident presents an immediate danger to himself or herself, staff, or other residents. According to HFS 132.31(1)(k), an emergency restraint may be used up to 12 hours without a physician's order. We expect that physician contact will occur as soon as possible after the restraint is applied or after the resident is placed in seclusion.

Section 51.61(1)(i), Wis. Stats., has additional requirements that apply when an emergency restraint is used on any person who has a mental illness or a developmental disability or who is protectively placed under chapter 55, Wis. Statutes. For example, staff must review the resident's status every 30 minutes and cannot use emergency isolation or a restraint beyond one hour unless authorized by the physician.

What deficient practices has BQA been citing in relation to physical restraints?

We have issued citations for the following deficient practices:

- Not being able to identify the medical symptom/condition being treated by the restraint.
- Using a physical restraint without comprehensively assessing the resident to understand the underlying basis of the medical symptom and whether staff could treat the symptom through staff interventions or through changes in the resident's environment, medications, social activities, etc.
- Not identifying alternative options to physical restraint use; not evaluating the risks/benefits of the different options; and, when indicated, not attempting other options as a first approach to treating the underlying medical symptom/condition.
- Not reassessing the continued need for a physical restraint as the resident's condition changed.
- Not fully involving residents/families/legal representatives as part of the care planning team.
- Not checking a restrained resident every two hours or more frequently as indicated by their condition.
- Not protecting the restrained resident from injury or death as a result of being restrained.
- Not adequately assessing, supervising, and/or using appropriate assistance devices or other clinical interventions to increase the safety of residents who had repeated falls.
- Not promoting restraint-free periods. This has been cited, for example, when the resident is in the dining room and continues to be restrained even when being supervised by staff.

Restraint Reduction. Since July 1996, there has been an 8% reduction in the percentage of Wisconsin nursing home residents who are physically restrained. We applaud the work that led to these results. We would like to make clear that **the goal of restraint reduction is not necessarily to become "restraint-free."** Rather, the goal of restraint reduction is to ensure that:

1. Facilities physically restrain only those residents who require a physical restraint to treat their condition, and

2. Residents are in the least restrictive restraint for the least amount of time possible. For example, if a restraint was used in an emergency when a resident posed a danger to him/herself or others,

staff should release the restraint when the resident is calm and no longer a threat. This also means that staff should promote restraint-free periods. For example, staff might release a resident's chair restraint when the resident is being directly supervised by staff, as may occur in the dining room or in activities.

A comprehensive assessment of the resident, like that outlined above, is the keystone for reducing restraints. Facilities attempting restraint reduction or attempting restraint reduction in response to a citation at F221 should not simply remove a restraint. Physiological changes from long-term restraint use may make the sudden removal of restraints dangerous. Robert Streimer, Director, Disabled and Elderly Health Programs Group, HCFA, has stated, "Where residents have been restrained and later found to no longer need restraints, we believe that it would be irresponsible on the part of a facility to remove restraints quickly, without a gradual and systematic process to remove a restraint one step at a time." The sudden removal of restraints (without prior evaluation for effective alternatives) has led to several resident falls and injuries over the past several months.

As a result, BQA does not necessarily expect that every resident identified on a citation at F221 will be completely free of restraints by the time of the revisit. A facility may determine that a resident first needs to be strengthened before gradually removing or modifying a restraint. In some cases, the facility may need to make environmental modifications (such as non-slip, softer surfaces and glare reduction from windows and doors). The survey team will look for evidence that the facility has worked with the resident, the attending physician, and the family or legal representative and has begun implementing a gradual and systematic plan for the eventual reduction of physical restraints.

It is less likely that BQA will cite F324 (accident prevention) when a resident falls after restraint reduction **if** a facility has followed a logical, systematic assessment process like that outlined on pages 3-6. In addition, there should be no avoidable contributing factors (such as medication overdose or untimely response to call lights). Similarly, BQA is less likely to issue a citation at F324 or F272 (assessment) **if**, after each fall, facility staff evaluate the circumstances of the fall, make a thorough assessment as to what changes, if any, should be made in the resident's care and care plan, and implement these changes.

Side Rails. A side rail may or may not be a restraint, regardless of whether the resident requests a side rail. You must ask the same two questions asked on page 2 of this memo to determine if a side rail is functioning as a restraint. A side rail is a restraint if the resident cannot lower the side rail, and the side rail:

- prevents a resident, who is otherwise capable of doing so, from safely and easily getting out of the side of the bed (voluntary movement); or
- prevents a resident from falling out of bed, if an assessment shows the resident moves about in bed to the extent that s/he is capable of falling; or
- prevents a resident from involuntarily being "thrown" out of bed because of a medical condition such as a seizure or because of involuntary movements due to a neurological condition.

The side rail is a restraint if it prevents a resident who would otherwise be capable of getting out of bed from getting out of bed, even if the resident does not realize s/he cannot walk once out of bed. (This is true even if the resident has been told to ask for assistance getting out of bed, but forgets to ask.) Before using a side rail as a restraint, a facility should work through an assessment like that outlined on pages 3-6. If a side rail meets the definition of a restraint, the side rail must be required to treat a medical symptom and there must be a physician's order for the side rail.

If the side rail does not prevent a resident from safely and easily getting out of the side of the bed at will or does not prevent a resident from involuntarily getting out of bed, the side rail is not a restraint. *This may occur when:*

(a) The resident uses the rail for assistance with mobility and can **safely and easily** go around the side rail, and the resident does not try climbing over the rail,

(b) The resident uses the rail for assistance with mobility and can easily get out of the opposite side of the bed by him/herself and does not try climbing over the rail,

(c) The resident can easily lower the side rail and safely get out the side of the bed, or

(d) The resident is unable to get out of bed by him/herself and **always** requires the assistance of another person. This means the resident is (i) unable to get out of bed without assistance, (ii) is unlikely to roll out of bed, (iii) is unlikely to be "thrown" out of bed because of medical or neurological conditions such as epilepsy or Huntington's chorea, and (iv) is unlikely to become wedged between the side rail and the bed.

Generally, a full-length rail will meet the definition of a restraint for a resident who is otherwise capable of getting out of bed if the resident cannot easily lower the rail or get out of the opposite side of the bed. A half-rail will generally meet the definition of a restraint for a resident who is otherwise capable of getting out of bed if the resident cannot easily lower the rail, cannot get out of the opposite side of the bed, or cannot easily go around the rail to get out of bed.

What if a resident uses a device that does not meet the definition of a restraint?

When a resident uses a restraint-like device that can be easily removed or which does not restrict free movement, staff should assess and care plan its use. Staff also should make sure that the device does not create a safety hazard for the resident. For example, if a resident uses a side rail for positioning and can safely and easily get out the side of the bed, staff should assure that the resident will not get caught between the rails or between the bed and the rail. Similarly, if a belt is used solely for positioning, staff should take necessary precautions to make sure the resident cannot passively slide down in the chair and get the belt caught around his/her neck. Staff need to monitor the use of these devices and to re-evaluate their safety, particularly as the resident's condition changes.

Can a competent resident request a restraint? Often, a competent resident will request a restraint. Most often, the resident requests a side rail because s/he worries about falling out of bed. A resident's right to participate in care planning and to refuse treatment, including the right of the resident to accept or refuse the use of side rails, must not be denied. Facility staff should:

- Assess the resident and the request. Determine why the resident is requesting the restraint.

- Describe to the resident alternative individualized care practices that may be safer and appropriate for the resident. Help the resident understand that these alternatives may help him or her to feel secure. Alternatives might include lowering the bed; placing cushions or an extra mattress on the floor next to the bed; placing pillows on the open side of the bed that prevent rolling but not getting out of bed; or getting a different type of bed. Staff might also check the resident more often and offer interventions such as toileting.

- Talk about the risks involved with the resident. Stress that *side rails are not benign safety devices and their use may pose a significant risk to the resident. In Wisconsin, in November*

1997 alone, there were two resident deaths due to side rails.

If the resident insists that s/he wants a side rail and makes an informed decision, the facility may use a side rail if it determines that the side rail can be safely used with the resident. We recommend getting signed consent from the resident and keeping this form on file. (Some facilities use a consent form that lists all the risks associated with restraint and/or side rail use.) If the side rail functions as a restraint, its use must be consistent with physician orders. We expect that staff will work with the resident to reduce the resident's anxiety about falling out of bed. In all cases, staff should monitor the safety of the rail so the resident does not become wedged between the bed/mattress and the rail or climb over the rail.

What if a legal representative insists on using a restraint? A facility should use a team approach to select effective individualized interventions for each resident. Everyone needs to be included, especially the resident, the legal representative, and physician. While legal representatives may refuse treatment options in accordance with their legal authority, they **cannot** dictate care that is not medically necessary or safe for the resident. The decision to use a restraint is a collective decision that rests with the interdisciplinary team. This team determines whether a physical restraint is required to treat the identified medical symptom. This is reflected in the guidance to surveyors found at F221 [42 CFR 483.13(a)]. This guideline states, "The surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely because a surrogate or representative has approved or requested them." Similarly, the interpretive guideline at F152 [42 CFR 483.10(a)(3)] states, "The involvement of a surrogate or representative does not automatically relieve a facility of its duty to protect and promote the resident's interests. For example, a surrogate or representative does not have the right to insist that a treatment be performed that is not medically appropriate..."

When a legal representative disagrees with the decision of the interdisciplinary team to reduce restraints or not to use a restraint, the facility should:

- Listen to the concerns and fears the legal representatives is raising to determine the underlying reasons for those fears and concerns. The facility, in turn, should convey its concerns about the significant potential hazards created by using a physical restraint. (These include a greater tendency to pressure ulcers, incontinence, urinary tract infection, dehydration, and malnutrition, loss of bone mass, loss of mobility, feeling like a prisoner, loss of self esteem, injuries from a fall, and death by asphyxiation.) Several videos are now available to assist in this education process. For example, the video series "Everyone Wins" is available in each BQA regional office and through several provider organizations. In addition, the pamphlet, *Avoiding Physical Restraint Use: New Standards in Care,* is available for residents and families. You may obtain a copy by writing or calling the National Citizen's Coalition for Nursing Home Reform, 1424 - 16th St. NW, Suite #202, Washington, DC 20036; phone 202-332-2275. Cost is $7.50 + $3.00 for shipping and handling.

- Upon hearing the concerns, staff should problem-solve with the legal representative who objects to restraint reduction. If the concern of a legal representative is that a resident may fall because the resident is weak, the legal representative may consent to restraint reduction if the resident first becomes involved in a strengthening program. Similarly, the legal representative may consent to restraint reduction if staff lower the bed or gradually phase in the program, beginning with supervised, short periods where the resident is not restrained. Staff might also invite the legal representative to talk with residents or the families of residents who have successfully become restraint free despite their initial misgivings.

- Contact the Ombudsman assigned to your facility. Ombudsmen are able to provide assistance in problem solving and in educating the legal representative about alternatives to restraint use.

When the wishes of the resident, guardian, or surrogate decision maker conflict with the recommendations of the interdisciplinary team, BQA expects facilities to attempt to educate the individual(s) about the dangers of using physical restraints. Staff should work toward developing an approach to which all parties can agree. This may include restraint reduction that is phased-in over a reasonable period of time.

The resident or legal representative should understand that the resident may fall and, depending upon staff evaluation of the fall, that a fall will not necessarily signal the immediate return to restraints. Being restraint-free does not necessarily mean being fall-free. However, research has shown that an unrestrained resident is two times less likely to fall and three times less likely to sustain a serious injury from a fall than a restrained resident (American Journal of Nursing, May 1992). For any resident who falls, including those in restraint reduction, staff should evaluate all the circumstances surrounding each fall. With this information, staff should determine what went wrong and what measures they should implement to reduce the possibility for further falls and to keep the resident safe. These measures should then be consistently implemented across all shifts each day of the week.

If you have any questions concerning restraint use and restraint reduction, please contact the Regional Field Operations Director or Supervisor at the phone number listed below.

Northeastern/Green Bay Regional Office:	Pat Benesh	920-448-5249
Northern/Rhinelander Regional Office:	Dolores Zwiers	920-448-5245
	Susan Murphy	715-836-4029
Southeastern/Milwaukee Regional Office:	Tony Oberbrunner	414-227-4908
Southern/Madison Regional Office:	Phyllis Tschumper	608-243-2374
Western/Eau Claire Regional Office:	Joe Bronner	715-836-4753

EXAMPLE OF RESTRAINT ASSESSMENT

1. Resident falls while getting out of bed. Resident is capable of movement that allows her to get out of bed or a chair but is unable to walk more than 5 feet without assistance.

2. Data collection. Staff determine that the resident is usually getting out of bed and falling near her bed between 4 and 5:00 a.m. The resident states that she is getting up because she has to go to the bathroom. She says her bladder must be getting weak because she never used to have to get up during the night to use the bathroom. The resident states that she uses her call light but staff are not responding quickly enough. When she gets to the point where she cannot hold it any longer she gets up and tries to make it to the bathroom by herself. The resident uses a wheel chair during the day but does not attempt independent transfer. She says that staff respond quickly to her requests to go to the bathroom during the day.

3. Assessment. The resident experiences orthostatic hypotension when getting up from a bed or chair. Her strength and muscle tone are weak. This has been exacerbated by a recent illness that has left the resident much weaker than usual. Blood sugar levels are high and may be contributing to nocturia. None of the resident's medications have side effects or interactions that could contribute to the resident getting up at night. One medication may be contributing to the resident's orthostatic hypotension. The resident does not have any conditions, such as severe osteoporosis, that could readily lead to a fracture if a fall occurs.

4. Options. Staff contact the physician for a possible change in the resident's medication, which might reduce the resident's orthostatic hypotension. Staff seek physician evaluation of the resident's blood sugar levels, since the onset of nocturia may be symptomatic of diabetes or a urinary tract infection. Staff seek evaluation by physical therapy for a strengthening program to help resident regain the strength needed to independently ambulate. Short-term approaches: Bed alarm to alert staff when the resident tries to get up out of bed. Anticipate resident's need to urinate during the night by waking her at 4:00 a.m. to assist her to the bathroom. Staff to promptly respond when the resident turns on her call light.

5. Consent. Staff talk with the resident (or legal representative if the resident has legally been declared not competent). Staff explain options so the resident (or legal representative) can make an informed decision. Staff obtain consent.

6. Attempt lesser restrictive measures. Implement short-term approaches and monitor for the effectiveness of reducing the number of falls.

7. Re-evaluate the effectiveness of this plan. Staff modify the plan as the resident's condition changes. Medication changes may reduce the resident's orthostatic hypotension and improvements in the resident's strength and gait may make the resident capable of independent transfer.

FREQUENTLY ASKED QUESTIONS ABOUT PHYSICAL RESTRAINTS

1. Is the ultimate goal of restraint reduction to make sure that every resident in every nursing home is restraint free?

No. The ultimate goal is to ensure that the only residents who are physically restrained are those who require a physical restraint to treat their condition and to help them achieve their highest practicable level of functioning and well being. When restraints are used, the restraint should be the least restrictive and should be used for the least amount of time possible. (See page 7.)

2. How do I count physical restraints for purposes of reporting on the HCFA-672 form, Resident Census and Conditions of Residents?

First, you must identify the residents who use a device such as a side rail, a wedge cushion, a lap buddy, a geri-chair, a reclining chair, or anything else that might be considered a restraint. Secondly, you must identify what movement each resident is capable of making. Once you identify these residents you must determine, for each resident, whether the device restricts the resident's free movement or normal access to his or her body. Then you must evaluate whether the resident can easily remove the device. *If the device restricts movement and the resident cannot easily remove it, the device is a restraint and you must count the resident as a person who is physically restrained.* If the device does not restrict movement or normal access to one's body, or if the resident can easily remove the device, it is NOT a restraint and should not be counted or reported as one. (See page 3.)

3. When is a side rail considered a restraint?

A side rail, no matter what the length, is considered a restraint when it cannot be easily lowered by the resident and:

- it prevents a resident who is capable of getting out of bed by him or herself, from safely and easily getting out the side of the bed (either around a half-rail, or the side of bed opposite a full-length or a half-rail), or
- it keeps a resident in bed who is capable of either rolling out of bed or involuntarily being "thrown" out of bed because of a medical or neurological condition such as epilepsy.

A side rail, regardless of length, is not a restraint if it does not prevent a resident from easily getting out of a side of the bed. The latter may occur when the resident can safely and easily go around the side, when the resident can get out of the opposite side of the bed, or when the resident cannot get out of bed unless assisted by another person. (See pages 7 and 8.)

4. Can a side rail be used if a competent resident requests it?

A side rail, as well as any device that functions as a restraint, may be used if a competent resident, who has been informed of the risks, presented with alternative options, and made an informed consent, requests the restraint. We recommend that the resident give signed consent and that this form be kept in the resident's record. If the side rail functions as a restraint, its use should be consistent with physician orders. Facility staff should work with the resident to reduce his/her anxiety about falling out of bed and should make the resident aware of alternative measures they might implement to prevent injury from a fall. (See page 9.)

5. What if a legal representative disagrees with the facility's assessment that a restraining device should not be used?

A legal representative has the right to refuse treatment. However, s/he does not have the right to demand care or treatment that is not indicated by the resident's condition. Consequently, a family member or a legal surrogate cannot have a resident restrained when there is no medical reason for using a physical restraint.

A facility should work with the family member or legal surrogate by advising him or her of the risks of restraint use and by collectively developing approaches to which both can agree. These might include the gradual reduction of restraints while the resident participates in a strengthening program, or gradual reduction that begins with one-on-one supervision while the restraint is removed. A facility may also ask the Ombudsman assigned to their facility for assistance. (See pages 9 and 10.)

6. Is a wedge cushion a restraint if it prevents a resident from ambulating who would otherwise be capable of getting up and walking? The resident cannot easily remove the cushion.

Regardless of the type of device, you must ask two questions: (1) Within the context of the resident's capabilities, does the device restrict a resident's free movement or normal access to his/her body? (2) Is it difficult for the resident to remove the device? If the answer to both questions is "yes," the device is a restraint. In this case, because the wedge cushion prevents the resident from ambulating and because the resident cannot easily remove it, the wedge cushion is a restraint. (See page 2.)

7. Is the wedge cushion a restraint if the resident cannot get out of the chair and the cushion prevents the resident from passively sliding (vs. actively working to slide down) in the chair?

The wedge cushion is not preventing free movement and is not a restraint. If the wedge cushion prevents a resident from sliding out of the chair and the resident actively works at trying to slide out of the chair, then the wedge cushion is a restraint. (See page 2.)

8. What is a "medical symptom"?

A medical symptom is the physical and subjective manifestation of a diagnosis or condition, or a combination of diagnoses and conditions. Effective treatment of a medical symptom requires staff to:

- Identify the underlying condition(s);
- Comprehensively assess the underlying condition(s);
- Evaluate the effect and impact that other symptoms or conditions may have on the underlying condition; and
- Identify and thoroughly evaluate the various interventions that might be implemented to treat the medical symptom.

Falls may be a manifestation of an underlying condition. Effective treatment of falls *begins with* identifying all the underlying factors and conditions that may be contributing to the falls. (For example, staff may look for blood pressure changes, balance disturbance, medication side effects, not meeting the resident's needs, lack of aggressive rehabilitation/restorative care, lack of meaningful activities, failure to manipulate the resident's environment, etc.) (See page 3.)

9. The interdisciplinary team comprehensively assesses a resident. The team considers the pros and cons of using different options to keep a resident safe. It concludes that a restraint is the best approach for helping a resident attain or maintain his/her highest practicable level of functioning and well being. The resident and/or legal representative consents to the use of the restraint and the physician orders it. Why should the judgment of a surveyor, who has spent much less time with the resident than we have, be allowed to overrule and cite us for the decision that we made?

Even if a survey team disagrees with the conclusions, the chances of being cited are greatly reduced if a facility can provide evidence that a comprehensive, systematic interdisciplinary-team process has occurred and if there are no obvious errors in the decisions that were made. A surveyor needs to see that the facility has used a logical and systematic interdisciplinary-team approach to assessing a resident and reaching the conclusion that a restraint instead of another alternative is required to enable the resident to reach his/her highest practicable level of functioning. (See one possible process outlined on pages 3-6.) Staff should document the data and conclusions that were reached in each step of the process. Thorough documentation aids staff when reassessing a resident and serves as proof that the process has occurred. The survey team may cite F272 (assessment) and/or F221 (restraints) if the facility cannot provide evidence that it used a logical, comprehensive, systematic process and the resident is not achieving his/her highest practicable level of functioning. The survey team may cite F514 (documentation) if the process and conclusions can be satisfactorily explained to the team but were not fully documented.

10. Bottom line. When can a facility use a physical restraint?

A facility may use a restraint if the interdisciplinary team determines, through a comprehensive, logical and systematic assessment process, that a physical restraint is the least restrictive option required to treat a resident's medical symptom. Also, the restraint must enable the resident to achieve his/her highest practicable level of functioning and well being. Staff may use a side rail if a competent resident requests it and has been fully informed of risks and alternatives. (However, the resident should not be requesting a restraint to prevent falls caused by his/her attempts to walk and to care for basic needs prompted by staff failure to respond timely to call lights or to resident's needs.) Whenever a restraint is used, it is crucial that staff check the resident frequently to decrease the chance that injury or death from the restraint will occur. (See page 3.)

A device that does not restrict a resident's free movement, or which a resident can easily remove, is not a restraint. However, facility staff should ensure that the device does not pose a safety threat to the resident who is using the device. (See page 8.)